Workgroup #3 – Medical Home

Goal: To reduce costs and increase quality care, every Iowan should have a patient centered medical home which emphasizes preventive care and wellness programs.

I. **Definition of Medical Home.** The definition of Medical Home is based up on the American Academy of Family Physicians patient centered medical home concept. The subcommittee recommends replacing the word physician with provider. The new definition is:

1. Personal Provider – each patient has an ongoing relationship with a personal provider trained to provide first contact, continuous and comprehensive care.

2. Provider directed medical practice – the personal provider leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

3. Whole person orientation – the personal provider is responsible for providing for all the patients health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

4. Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

5. Quality and safety are hallmarks of the medical home:

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between providers, patients, and the patient's family.
- Evidence-based medicine and clinical decision-support tools guide decision making.
- Providers in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.
- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.
- Patients and families participate in quality improvement activities at the practice level.

6. Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal provider, and practice staff.

7. Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

- It should reflect the value of provider and non-provider staff patient-centered care management work that falls outside of the face-to-face visit.
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- It should support adoption and use of health information technology for quality improvement.
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation.
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).
- It should recognize case mix differences in the patient population being treated within the practice.
- It should allow providers to share in savings from reduced hospitalizations associated with provider-guided care management in the office setting.
- It should allow for additional payments for achieving measurable and continuous quality improvements.

II. Purposes – A patient centered medical home emphasis serves two purposes:

- Having a patient centered medical home is a tangible method to document if a given Iowan truly has access to healthcare.
- It is believed that the use of certified patient centered medical homes improves quality and lowers healthcare costs. Widespread, if not universal, use of certified patient centered medical homes will create healthcare savings that will allow more Iowans to be insured and further will improve the possibility of our proposed actions to be sustainable.

III. Commission Proposal – Creation of the Iowa Medical Home Board to determine the qualifications for, and certify, a patient centered medical home. The IMHB will be under the direction of the Iowa Department of Public Health.

1. Improving quality and reducing healthcare costs:

- For the expressed and only purpose of improving quality and lowering healthcare costs, Iowa will adopt a process to certify patient centered medical homes. It is anticipated that this process will utilize the upcoming National Committee for Quality Assurance's standards to certify patient centered medical homes, in whole or near total, based on a review by the Iowa Medical Home Board. The group considered similar standards proposed by the Iowa Department of Public Health and Dr. Carlyle (see Addendum.)

- Iowa will encourage, promote, and if possible, fund efforts to transform medical practices into certified patient centered medical homes with special emphasis on such practices obtaining Electronic Medical Records.

2. Education and Training Standards. The Board will provide suggestions to specific education and training standards for providers of a medical home. *The Board will work with the University of Iowa Hospitals and Clinics, Des Moines University, Mercy College, and others. (Certification for uniform implementation)*

3. Incentives for Providers. The Board will provide suggestions of incentives to become a certified patient centered medical home. The Board will analyze at least the following criteria when determining potential incentives. The board is required to look at the financial feasibility of any incentive.

- Items not reimbursed for Medicaid by DHS to promote wellness, and prevention of chronic disease management
- Increase rates to Medicare levels for certain wellness, prevention, chronic disease management services, immunizations
- *Other*

4. Iowa Medical Home Board Membership. The Director of Iowa Department of Public Health will head the Iowa Medical Home Board. The other members of the board will consist of the Director of Iowa Department of Human Services, the Iowa Insurance Commissioner, *and*...

IV. Commission Proposal – Implementation and Oversight.

1. Programs under the State of Iowa. Iowa will, where possible, pay certified patient centered medical homes to care for patients under its authority, e.g. Medicaid, hawk-i, the IowaCare Program, state employees and any new insurance pool created by the Commission.

2. Other Programs. Iowa will with other insurance entities and self-funded companies to create a multi-payer effort to pay certified patient centered medical homes for care of patients utilizing common certifying and reporting mechanisms. Iowa will work with Medicare directly or via a Medicare Advantage route to allow Medicare patients to utilize this common certified patient centered medical home project.

3. Oversight of Medical Home. The Board will have oversight over all certified patient centered medical homes. If after review of this certified patient centered medical home project it is determined that either quality was not improved and/or health care costs were not reduced

Policy Questions of Medical Home Group:

- What standards will be used?
- What levels are there for medical homes?
- How will cost savings be measured?
- Should there be an appointed Iowa Medical Home Board?
- Membership of Iowa Medical Home Board?
- Dental, vision, pharmaceutical home? (children should have a dental home)
- How will the all payer database be integrated in to the certified patient centered medical home?

- What other incentives should the Board be required to look at to encourage practices to become a certified patient centered medical home?
- Other questions?

Addendum

Family Involvement

- "Perceptions of care" feedback from patients/families with chronic conditions is systematically gathered (e.g. using surveys, focus groups, or interviews of ≥10 families) at least every six months.
- There is an established process for practice staff to review this feedback and, based on the feedback, to plan and implement change.

Care Coordination

- The primary care practice (PCP) intermittently, but deliberately, asks any patient/family with a chronic condition what additional care supports they need.
- The primary care provider or a staff member helps patients/families, as requested, obtain resource information and coordinate appointments.
- If not provided directly by the PCP, the practice assumes responsibility to connect patients/families needing care coordination with other available care coordination resources.

Special Patient Identification and Data Monitoring

- A registry list (electronic or otherwise) of patients with special health care needs[5] is generated to enhance planning and delivery of quality care.
- The registry list is used for tracking, monitoring, and flagging such things as vaccines; use of other evidence-based clinical guidelines; sequential lab values; or abnormal test results.
- Out-of-practice referrals are tracked and documented to assure that a full information picture about the patient/family is available to the PCP.

Continuity of Care

- The care team (including primary care physician, staff, and patient/family) collaboratively develops a care plan[6] that identifies needs for services/referrals and assures communication between PCP, patient/family, and other care providers (e.g., specialists, cross-coverage providers, and emergency providers).
- The care plan is in the patient's chart along with documentation of where and to whom it has been distributed.
- The plan of care is reviewed, updated, and re-documented at least twice per year (at 6 month intervals) by the care team.

Cultural Competence

- The primary care practice (PCP) attempts to address obstacles of language, literacy, or personal preferences by having resources and information available for the most common diverse cultural backgrounds in the catchment area.
- When useful for care, individual patients/families are assisted through efforts to obtain interpreters or to access culturally-relevant information from outside sources.
- Culturally-related accommodation needs are documented for future clinic visits.

Transition Support

- PCP providers, on an intermittent basis, initiate and document age and situation-relevant discussions with patients/families about transition issues.
- The primary care provider or a staff member assists patients/families, as requested, to obtain resources useful for planning successful life transitions.

Self-Management Support

- The PCP assesses the patient's/family's ability to understand and manage their health condition.
- Based on the assessment, the PCP assists the patient/family to live with their chronic condition using evidence-based self-management strategies[8].
- The self-management plan is reviewed and documented at intervals appropriate to patient/family needs.

Practice-Based Continuous Quality Improvement

- The PCP has its own documented systematic quality improvement mechanism for patient care.
- Regular PCP provider and staff meetings discuss how to improve care and treatment, including reflections on the PCP's use of evidence-based guidelines; status of patient and staff satisfaction; and ease of patient/family access to care.

Access

- Same day access
- After hours processes
- Triage
- Continuity of care with same provider

Patient Registry

- Evidence-based population guidelines
- Electronic
- Data organization

Care Management

- Prevention cues for provider
- Team approach
- Continuity of care

Patient Self-Management Support

- Recognize and respond to cultural/language needs
- Standard information to be given

Electronic Prescribing

- Decision support

Test Tracking

Referral Monitoring

Quality Reporting and Improvement

- Patient safety

Patient Electronic Communication

- Patient results
- Patient basic medical data
- Patient questions